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**CONSENT TO OBTAIN A MEDICAL REPORT & PAST MEDICAL RECORDS**

(Please complete in black ink and return to Medicalaw as soon as possible)

Title :	First Name :	Surname :
Address (including post code) :		
Telephone :	Date of Birth :	
Mobile :		

GENERAL PRACTITIONER	
Name :	
Address (including post code) :	
Tel No :	Date of Accident :

HOSPITAL ATTENDED (related to accident only) :
Address (including post code) :
Details of X-rays/CT/MRI Scans taken and relating to accident only :

<p>I consent to be examined by a health professional appointed by Medicalaw.</p> <p>I authorise the disclosure of my full GP records and hospital records, both past and present, to Medicalaw and/or the health professional appointed by Medicalaw. I am also fully aware of the reasons why they are required, to whom they will be supplied and that the records may be stored and delivered electronically.</p> <p>I do not intend to take any legal action against the practitioner/health authority or any of its employees.</p> <p>Signed : ..... Date : .....</p>
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